Cal-COBRA Continuation Coverage Election Form

PART A – Employee Information

Employee's Name: Last / First / Middle Initial			Social Security Number or Anthem ID / /
Gender: Male ☐ Female ☐	Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated ☐		Date of Birth (Month-Day-Year) / /
Address		Home Phone Number	Work Phone Number
City	State	Zip Code	

PART B – Type of Qualifying Event - Check One Qualifying Event and Date of Qualifying Event

Cal-COBRA Qualifying Event	Date of Qualifying Event
☐ Termination or Reduction in Hours	Last Day Worked or Date Hours Reduced:
☐ Divorce or Legal Separation	Divorce/Legal Separation:
☐ Dependent Child No Longer Eligible	Event Date:
☐ Death of Covered Employee	Date:
☐ Termination of Domestic Partnership	Date of Termination:

PART C – Coverage Election – Check One to indicate which dependents are electing Continuation Coverage

- ☐ Employee & All Dependents Currently Enrolled
- ☐ Employee & Spouse
- ☐ Employee Only
- ☐ Employee & Dependent Child(ren) – Complete Section D
- ☐ Spouse or Dependent(s) Listed – Complete Section D

PART D – Dependent Information – Complete this section if you elected Employee & Dependent Child(ren) or Spouse or Dependent(s) in Section C. *Note - Only include dependent's Social Security Number if Employee is **not** electing Continuation Coverage.

Relationship To Employee	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Employee's)	Gender		Date of Birth Month/Day/Year	*Social Security Number (See Note)
Spouse		M	F	/ /	
Dependent Child		M	F	/ /	
Dependent Child		M	F	/ /	
Dependent Child		M	F	/ /	

PART E – Payment Options - Select One Payment Option – Do not send a payment with this Election Form

☐ **C. Check –** You will be billed on a monthly basis

☐ **A. Direct Withdrawal from Checking Account -** The first premium will be charged upon enrollment. Future premiums will be charged to your account around the 6th business day of each month.

Name on Checking Account: ______________________________ Bank Name: ______________________________

Routing Number: ______________________________ Checking Account Number: ______________________________

PART F - Applicant Signature

I have elected to continue coverage under this plan due to the qualifying event indicated above and I understand that in order to retain my continuation coverage, I must meet the required payment obligations and/or other conditions as may be required. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties. Refer to Note back of form for additional information. **Applicant Signature:** **Date:**

Send Completed Form to:
Anthem Dental Enrollment
Attn: Enrollment Department – Cal-COBRA
PO Box 1193
Minneapolis MN 55440-1193

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***Please examine your options carefully before declining this coverage. You should be aware that companies selling individual dental insurance typically require a review of your dental history that could result in a higher premium or you could be denied coverage entirely.*

Notes to Employee:

- *California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.*
- *REQUIREMENT FOR BINDING ARBITRATION The following provision does not apply to class actions: IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.*

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